

\_\_\_\_\_ District

Certificate of  
Fitness for Duty

\_\_\_\_\_ (employee's name) is a patient of mine. It is my

understanding that \_\_\_\_\_'s (employee's name) employment

with the \_\_\_\_\_ School District requires him/her to be able to perform

the following activities with accompanying weekly time requirements:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

On \_\_\_\_\_,(date) I personally evaluated \_\_\_\_\_  
(employee's name). I certify that based upon my education and clinical  
expertise \_\_\_\_\_ (employee's name) is fit to return to his/her  
employment with the \_\_\_\_\_ District.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title